GOOD AFTERNOON.
THIS IS LAURA CHEEVER, THE ASSOCIATE ADMINISTRATOR OF THE HIV/AIDS BUREAU AT HRSA AND WELCOME TO OUR FIFTH WEBINAR IN OUR SERIES WITH THE RYAN WHITE GRANTEES AND THE TRANSITION TO FULL IMPLEMENTATION OF THE AFFORDABLE CARE ACT.
TODAY'S WEBINAR IS THE INTERSECTION OF THE RYAN WHITE HIV PROGRAM WITH THE ESSENTIAL HEALTH BENEFIT IN PRIVATE HEALTH INSURANCE AND MEDICAID.
THE PURPOSE OF TODAY'S WEBINAR IS TO EDUCATE RYAN WHITE GRANTEES ABOUT COVERAGE OPTIONS IN ESSENTIAL HEALTH BENEFITS AVAILABLE TO PEOPLE LIVING WITH HIV THROUGH THE MARKETPLACE.
WE'LL REVIEW INDIVIDUAL AND SMALL GROUP COMMERCIAL PLAN COVERAGE OF ESSENTIAL HEALTH BENEFIT INSIDE AND OUTSIDE OF HEALTH INSURANCE MARKETPLACE AND THIS WILL BE DONE BY COLLEAGUES AT CMS CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, OTHERWISE CALLED CCIIO.
AND FOR CHAMPIONSHIP SERVICES, WE'LL REVIEW THAT.
AND FINALLY, COLLEAGUES FROM THE OFFICE OF POLICY AND EVALUATION HERE IN HRSA WILL ASSIST US IN THAT PART OF THE WEBINAR.
BEFORE WE BEGIN, HOWEVER, I WANT TO REVIEW WHAT HEALTH CARE COVERAGE OPTIONS FOR PEOPLE LIVING WITH HIV LOOKED LIKE BEFORE THE AFFORDABLE CARE ACT.
MANY PEOPLE CONSIDERED RYAN WHITE A PROGRAM FOR THE UNINSURED BUT, IN FACT, IT'S A PROGRAM FOR THE UNINSURED AND UNDER INSURED AND WE LOOK AT DATA FROM OUR 2010 CLIENT LEVEL DATA WITHIN THE RYAN WHITE PROGRAM, WE SEE THAT ABOUT 29% OF PATIENTS THAT ARE RYAN WHITE CLIENTS ACTUALLY ALSO ARE COVERED BY MEDICAID.
25% HAVE NO INSURANCE AND ARE TRULY UNINSURED.
13% HAVE PRIVATE INSURANCE.
12% HAVE HAD MULTIPLE INSURANCE TIMES.
9% MEDICAID, 8% OTHER INSURANCE AND 4% FOR OTHER INSURANCE CAT

GOES.
OVERALL, ABOUT 75% OF CLIENTS IN THE RYAN WHITE PROGRAM DO HAVE SOME SORT OF COVERAGE AS THEY PARTICIPATE IN RYAN WHITE.
NEXT SLIDE, PLEASE.
AMP THE AFFORDABLE CARE ACT THIS WILL CHANGE CONSIDERABLY.
PARTICULARLY IN STATES WITH MEDICAID EXPANSION.
IN TEASE STATES, MANY PEOPLE LIVING WITH HIV WILL BE ELIGIBLE FOR HEALTH CARE COVERAGE INCLUDING EMPLOYER-BASED INSURANCE, MEDICAID, MEDICARE, OTHER PUBLIC INSURANCE, THE HEALTH INSURANCE MARKETPLACE AND OTHER PRIVATE PROGRAMS.
THE RYAN WHITE PROGRAM WILL CONTINUE TO PROVIDE SERVICES FOR THESE -- FOR PEOPLE ENROLLED IN THESE PROGRAMS, INCLUDING COVERAGE FOR COMPREHENSIVE MEDICAL AND SUPPORT SERVICES NOT COVERED OR PARTIALLY COVERED BY THEIR PUBLIC PROGRAMS OR PRIVATE INSURANCE.
AS WELL, THE RYAN WHITE PROGRAM WILL CONTINUE TO SERVE PEOPLE LIVING WITH HIV WHO WILL REMAIN UNINSURED IN THE FULL EXPANSION OF MEDICAID.
NOW I'M GOING TO TURN THE MIKE OVER TO LISA COUZZO WHO WORKS IN CCIIO AND WILL WORK WITH OTHER THE PARTICIPATING IN ON THE CALL.
>> THANK YOU VERY MUCH.
GOOD AFTERNOON EVERYONE.
I AM A MEMBER OF THE EXCHANGE PLAN MANAGEMENT DIVISION OF CCIIO, AND ONE OF THE INDIVIDUALS WHO WORKED ON THE ESSENTIAL HEALTH BENEFITS REGULATION WITH ME IS ALISON WILY, AND HELAINE FINGOLD WHO ALSO WORKED ON THE ESSENTIAL BENEFITS RIG AND WE ARE GOING TO GO OVER A FEW SLIDES JUST TO GIVE A HIGH LEVEL OVERVIEW OF THE ESSENTIAL HEALTH BENEFIT REGULATION, WHICH WAS RELEASED EARLIER THIS YEAR.
AND A LINK IS AVAILABLE ON THE CCIIO WEBSITE TO THE REGULATION ITSELF AS WELL AS OTHER PERTINENT INFORMATION.
NEXT SLIDE, PLEASE.

SLIDE SIX.
THANK YOU.
UNDER THE AFFORDABLE CARE ACT
NON-GRANDFATHERED HEALTH PLANS
IN THE INDIVIDUAL AND SMALL
GROUP MARKET MUST COVER THE
ESSENTIAL HEALTH BENEFITS
PACKAGE.
THIS IS BOTH INSIDE AND OUTSIDE
OF THE EXCHANGE.
OFTEN TIMES PEOPLE THINK THAT
THE ESSENTIAL HEALTH BENEFITS
ARE ONLY REQUIRED INSIDE OF
EXCHANGE, BUT THAT IS NOT THE
CASE.
IT'S ALL INDIVIDUAL AND SMALL
GROUP MARKET PLANS.
THEY MUST COVER AT LEAST THE TEN
CATEGORIES OF BENEFITS AND
SERVICES THAT ARE CALLED OUT BY
THE AFFORDABLE CARE ACT.
THEY MUST MEET CERTAIN ACTUARIAL
STANDARDS AND HAVE CERTAIN
LIMITS ON COST SHARING.
AND THE FOLLOWING SLIDES WILL GO
IN TO THOSE THREE THINGS IN MORE
DETAIL.
SLIDE SEVEN, PLEASE.
THANK YOU.
THIS SLIDE JUST GIVES YOU THE
TEN CATEGORIES OF BENEFITS AND
SERVICES THAT ARE OUTLINED IN
THE AFFORDABLE CARE ACT.
AND AS I SAID, ALL PLANS IN THE
INDIVIDUAL AND SMALL GROUP
MARKET MUST COVER AT LEAST THESE
TEN CATEGORIES.
YOU SEE THAT THE TEN CATEGORIES
ARE RATHER HIGH LEVEL, AND THERE
MAY BE SOME OVERLAP, BUT WE LEFT
IT TO THE STATES TO DECIDE WHICH
BENEFITS FALL INTO WHICH OF
THESE CATEGORIES.
HOWEVER, BEFORE AN INDIVIDUAL OR
SMALL GROUP PLAN CAN BE SOLD,
STARTING IN 2014, IT MUST COVER
ALL TEN OF THESE BENEFITS AS
SERVICE CATEGORIES, AND CAN
COVER MORE.
THIS IS JUST THE MINIMUM
STANDARD.
SLIDE EIGHT, PLEASE.
IN CREATING THE ESSENTIAL HEALTH
BENEFITS PACKAGES, EACH STATE
WAS ASKED TO SELECT A BENCHMARK
PLAN, AND THE BENCHMARK PLAN
OPTIONS, THERE WERE TEN OPTIONS.

SMALL GROUP PLANS, EMPLOYER
PLAN, FEDERAL EMPLOYEE HEALTH
PLAN, AND HMO PLANS.
AND THE BENCHMARK OPTIONS WERE
PLANS TYPICALLY OFFERED BY SMALL
EMPLOYERS.
THAT WOULD BE MOST CHOSEN
BENCHMARK WAS A SMALL GROUP
PLAN, IN MOST STATES.
WE DID THIS ACCORDING TO A STATE
CHOSEN BENCHMARK PLAN, BUT WE
COULD PRESERVE STATE FLEXIBILITY
ALLOWING THE STATE TO DECIDE
WHAT ITS BENCHMARK BENEFITS
WOULD BE.
THIS IS SIMILAR TO THE BENCHMARK
APPROACH THAT IS CURRENTLY USED
IN OTHER PROGRAMS.
AT CMS.
THE BENCHMARK PLAN WAS SELECTED
IN THE FIRST QUARTER OF 2012.
BUT THEY HAD TO CONFORM TO ALL
ACA REQUIREMENTS STARTING IN
2014
SO EVEN IF THE BENCHMARK PLAN
MAY CONTAIN ANNUAL LIMITS OR NOT
COMPLY WITH OTHER ACA
REQUIREMENTS THAT WE'LL TALK
ABOUT, THEY MUST COMPLY WITH
THOSE IN 2014.
NEXT SLIDE.
SINCE THE ESSENTIAL HEALTH
BENEFITS MUST COVER ALL TEN OF
THE CATEGORIES LISTED EARLIER,
IF THE STATE-CHOSEN BENCHMARKS
PLAN DID NOT COVER ONE OF THOSE
CATEGORIES, THE STATE HAD TO
SUPPLEMENT BY FILLING THAT
CATEGORY WITH THE BENEFITS FROM
ANOTHER BENCHMARK PLAN.
THIS ENSURED THAT THE BENCHMARK
PLAN COVERED ALL TEN OF THE
CATEGORIES.
THE BENCHMARK PLAN SERVES AS
REFERENCE PLAN SO THAT ALL PLANS
WHO OFFER ESSENTIAL HEALTH
BENEFITS START IN 2014 MUST BE
SUBSTANTIALLY EQUAL TO THE
BENCHMARK PLAN IN THEIR STATES.
A NUMBER OF STATES BENCHMARK
PLANS DID NOT COVER PEDIATRIC
ORAL AND VISION CARE, WHICH IS
ONE OF THE CATEGORY, AND IN THAT
KASHGS
CASE, THE STATE WAS PERMITTED TO
SUPPLEMENT THAT MISSING CATEGORY
WITH EITHER THE FED BENEFITS OR

THE STATE CHIP PLAN BENEFITS, IF
THE STATE HAD SUCH A CHIP PLAN.
NEXT SLIDE, PLEASE.
ANOTHER CATEGORY THAT WAS OFTEN
NEEDED TO BE SUPPLEMENTED WAS
REHABILITATIVE SERVICES.
ONE OF THE CATEGORIES IS
REHABILITATIVE AND HAS BILL
REHABILITATIVE SERVICE, AND DEVICES AND
A NUMBER OF THE STATE BENCHMARK
PLANS DID NOT INCLUDE COVERAGE
OF HABILITATED SERVICES'S IN
THAT CASE, IF THE BENCHMARK PLAN
DID NOT COVER HAB SERVICE, THE
STATE MAY DETERMINE WHAT THAT
COVERAGE MUST BE.
IF THE BENCHMARK PLAN DIDN'T
DETERMINE AND THE STATE DID NOT
EITHER, THEN IT'S UP TO THE PLAN
TO EITHER PROVIDE PARITY BETWEEN
HABILITATIVE OR WHAT IT COULD
COVER AND REPORT THAT TO HHS.
IF WE COULD GO TO THE NEXT
SLIDE, PLEASE.
11
I'M GOING TO TURN IT OVER TO MY
COLLEAGUE, ALISON WILY.
>> THANKS, LISA.
SO FOR THE PRESCRIPTION DRUG
BENEFIT PORTION OF THE ESSENTIAL
HEALTH BENEFITS WE REQUIRE THAT
PLANS COVER AT LEAST THE GREATER
OF ONE DRUG IN EVERY USP IN THE
UNITED STATES PhRMA CAPIA CLASS
OR THE SAME NUMBER IN CATEGORY
AND CLASS AS THE EHB BENCHMARCH
PLAN.
SO TO BETTER EXPLAIN THAT, IF
THE BENCHMARK PLAN DOESN'T COVER
A DRUG IN A PARTICULAR CATEGORY
OR CLASS, THE PLAN HAS TO COVER
ONE DRUG.
BUT IF THE BENCHMARK PLAN COVERS
FIVE DRUGS IN A PARTICULAR
CATEGORY OR CLASS, THE PLAN IS
REQUIRED TO COVER THE FIVE
DRUGS.
AS PER THE PRESCRIPTION DRUG
BENEFIT POLICY, PLANS ARE ALSO
REQUIRED TO HAVE AN EXCEPTIONS
PROCESS IN PLACE SO ENROLLEES
CAN GAIN ACCESS TO DRUGS NOT ON
THE PLAN'S LIST, AND BACKGROUND
INFORMATION REGARDING THAT ISSUE
CAN BE FOUND IN ONE OF THE LINKS
TO TODAY'S MEETING UNDER THE
2014 LETTER TO ISSUERS.

ALSO THE DISCRIMINATION
PROTECTIONS AND THE ESSENTIAL
HEALTH BENEFITS FINAL RULE
APPLIES TO THE DRUG POLICY AS
WELL.
SLIDE?
NEXT SLIDE.
SO THE -- THE NEXT AREA THAT WE
WANTED TO DISCUSS WAS THE
ESSENTIAL HEALTH BENEFITS
PROVISIONS ON MENTAL HEALTH AND
SUBSTANCE ABUSE BENEFIT.
FOR THESE BENEFITS, WE TLIR THE
PLANS ARE WITH PARITY STANDARDS
WITH THE MENTAL HEALTH PARITY
WITH 2008.
THIS EXTENDS THE SS THE PARITY TO SMALL
GROUP PLAN.
NEXT SLIDE.
MOVING ON TO ACTUARIAL VALUE.
SO TO HELP CONSUMERS COMPARE
PLANS, WE USED -- TO THE
RELATIVE GENEROSITY OF PLAN
DESIGNS WE USED ACTUARIAL VALUE.
THAT'S THE TOTAL OVERALL HEALTH
CARE COSTS CONTRACTED BY THE
TOTAL ENROLLEE COSTS OVER THE
OVERALL HEALTH CARE COSTS, WHICH
EQUALS, COMES OUT TO, A
PERCENTAGE RATE.
AND TO BE CLEAR, AV MUST BE
CALCULATED ON THE PROVISIONS OF
AHD TO THE STANDARD POPULATION.
SO IT'S NOT BASED ON THE
INDIVIDUAL.
IT'S BASED ON THE STANDARD
POPULATION AS A WHOLE, AND
SHOULD BE SEEN AS AN EMPIRICAL
ESTIMATE.
NEXT SLIDE.
SO PER THE AFFORDABLE CARE ACT,
AV DETERMINES THE LEVEL OF
COVERAGE AND THE LEVEL OF
COVERAGE IS BASED ON METAL TIER
LEVELS AS YOU SEE DESCRIBED IN
THIS SLIDE.
WITH PLANS EQUALLING AN
ACTUARIAL VALUE OF 60%, SILVER
WITH 70%, GOLD PLANS WITH 80%,
AND PLATINUM PLANS WITH 90%.
AND FOR THESE PLAN DESIGNS
THERE'S ALSO A DEMINUTUS RANGE,
RELATIVE TO THEM.
I'M NOW GOING TO TURN IT OVER TO
MY COLLEAGUE COLLEEN TO GO INTO
THE DISCRIMINATION PROVISION.
>> HI.

SO IN ADDITION AS PART OF THE ESSENTIAL HEALTH BENEFITS REQUIREMENTS, PLANS ARE PROHIBITED FROM DISCRIMINATING IN THEIR BENEFITS DESIGN OR IMPLEMENTATION OF THEIR BENEFIT DESIGN.
BASED ON A PERSON'S AGE, EXPECTED LENGTH OF LIFE, DISABILITY, MEDICAL DEPENDENCY, QUALITY OF LIFE AND OTHER HEALTH CONDITIONS.
NOW, IT NEEDS TO BE POINTED OUT, THOUGH, THAT THIS DOES NOT PROHIBIT PLANS FROM CONDUCTING WHAT ARE CALLED REASONABLE MEDICAL MANAGEMENT TECHNIQUES.
SO, FOR EXAMPLE, YOU KNOW, THEY HAVE TO COVER, LET'S SAY THEY OFFER THE -- A KIND OF A VACCINE.
LIKE A CHILDHOOD VACCINE TO CHILDREN.
THEY WOULDN'T HAVE TO COVER THAT FOR ADULTS, IF THAT'S NOT A MEDICALLY REASONABLE THING TO OFFER.
SO IT DOESN'T MEAN THAT THERE'S NO DISTINCTION THEY CAN MAKE BASE AND AGE.
IT MEANS THAT THEY HAVE TO HAVE -- IT HAS TO BE BASED ON, AGAIN, REASONABLE MEDICAL MANAGEMENT TECHNIQUES.
SO THAT'S HOW THOSE NON-DISCRIMINATION STANDARDS ARE APPLIED.
NEXT – NEXT SLIDE.
THE ACA ALSO CREATED AND APPLIES COST SHARE AND PROTECTIONS FOR CONSUMERS.
BEGINNING WITH JANUARY 2014.
THERE ARE ANNUAL LIMITS BOTH ON THE DEDUCTIBLE SIDE AND ON MAXIMUM OUT OF POCKET AMOUNTS.
HOWEVER, THEY APPLY TO DIFFERENT FAMILIES OF PLANS.
SO LET'S LOOK AT THOSE A LITTLE MORE CLOSELY.
FOR THE -- THE MAXIMUM OUT OF POCKET AMOUNTS, WHICH APPLIES TO COST SHARING, CO-PAYS, DEDUCTIBLES, AND SIMILAR CHARGES CHARGES, THOSE APPLY TO ALL GROUP HEALTH PLANS, INCLUDING INDIVIDUAL PLANS.
SO EVERYBODY IS SUBJECT TO THESE

ANNUAL LIMITS.
THE LIMITS ARE $63.50 FOR AN INDIVIDUAL, OR DOUBLE THAT, $12,700 FOR FAMILY.
FOR NOT JUST THE INDIVIDUAL.
THESE AMOUNTS COME FROM THE IRS LIMITS FOR HIGH DEDUCTIBLE HEALTH PLANS, WHICH, AGAIN, FORMS THE AMOUNTS FOR THE 2014 PLAN YEAR.
STARTING WITH 2015, CMS WILL BE ADJUSTING THESE AMOUNTS BY THE PERCENTAGE THAT WE ARE ALLOWED PREMIUM ADJUSTMENTS.
SO THEY WILL THEN, AGAIN, GROW AS WE MOVE FORWARD.
NOW, THE OTHER THING TO NOTE IS THAT THESE OUT OF POCKET LIMITS APPLY.
THEY HAVE TO APPLY TO ESSENTIAL HEALTH BENEFITS.
SO WHEN SOMEBODY INSERTS THEIR OUT OF POCKET SPENDING ACCRUES TO THIS OUT OF POCKET LIMIT, AND LEM JUST BACK UP A LITTLE.
AN OUT OF POCKET LIMIT MEANS WHEN YOU AS THE INDIVIDUAL COVERED, MEET THAT LIMIT.
YOU'VE SPENT, YOU'VE PAID OFF YOUR DEDUCTIBLE.
YOU'VE PAID YOUR OUT OF POCKET COST-SHARING.
WHEN YOU MEET THAT LIMIT, $63.50, AFTER THAT, YOU DON'T HAVE TO PAY ANY ADDITIONAL COST SHARING, OR DEDUCTIBLE AMOUNT.
THAT'S WHEN THE PLAN KICKS IN MORE COVERAGE.
THE COVERAGE LEVEL IS HIGHER.
YOU'VE SPENT AS MUCH AS YOU ARE REQUIRED TO SPEND FOR THE COVERED SERVICES, FOR THE COVERED EHB SERVICES.
THAT DOESN'T MEAN THAT THERE'S NOTHING ELSE YOU'LL HAVE TO PAY, BUT, AGAIN IS IT LIMIT THE COST SHARING ON THE EHB SERVICES, IN ADDITION, IN YOU'RE IN A NETWORK-BASED PLAN, FOR EHB AS MUCH AS THAT YOU GET IN NETWORK.
SO THIS DOESN'T LIMIT YOUR OUT OF NETWORK COSTS, OR YOUR COSTS FOR NON-EHB SERVICES, OR, YOU KNOW, NON-COVERED SERVICES.
OBVIOUSLY.
SO, AGAIN THAT APPLIES TO GROUP HEALTH PLANS AND INDIVIDUALS.

SO IT'S BOTH SMALL EMPLOYER
PLANS, AS WELL AS LARGE EMPLOYER
PLANS AND SELF-INSURED PLANS.
THERE ARE ALSO DEDUCTIBLE
LIMITS, WHICH APPLY JUST TO
SMALL GROUP EMPLOYER PLANS.
AND THOSE LIMITS ARE $2,000 FOR
AN INDIVIDUAL COVERAGE, AND
$4,000 FOR THE FAMILY COVERAGE.
AGAIN, THE DEDUCTIBLE APPLIES TO
THE EHB.
THE ESSENTIAL HEALTH BENEFITS.
SO AS AN IN-NETWORK AMOUNT.
THAT'S IT FOR US IN THE EHB.
EHB WORLD.
WE'RE GOING TO TURN BACK OVER
FOR THE MEDICAID DISCUSSION.
>> GREAT.
THANK YOU.
THIS IS YOLANDA CAMPBELL FROM
THE OFFICE OF ANALYSIS AND
EVALUATION.
I WANT TO THANK LISA HELENE AND
ALISON FOR YOUR DESCRIPTION, AND
WHAT IS SENT TO PRIVATE
INSURANCE PLANS BOTH INSIDE AND
OUTSIDE THE MARKETPLACE.
I ALSO WANT TO REMIND THE
AUDIENCE WE WILL BE TAKING CALLS
AT THE END OF THE PRESENTATION,
AND THAT WE ARE RECEIVING YOUR
E-MAILS THROUGHOUT THE
PRESENTATION AND WILL ADDRESS
THE QUESTIONS AS WE CAN AT THE
END OF THE PRESENTATION.
SO, PLEASE, FEEL FREE TO SUBMIT
YOUR QUESTIONS AS THE
PRESENTATION PROCEEDS.
NEXT I'D LIKE TO INTRODUCE
MELISSA HARRIS AND CHRISTINE
VINES FROM EMPS AND THEY'RE
GOING TO TALK ABOUT THE MEDICAID
ALTERNATIVE BENEFIT PLAN, AND
THE ESSENTIAL HEALTH BENEFIT.
SO MELISSA, I'LL HAND IT OVER TO
YOU.
THANK YOU.
>> THANK YOU, YOLANDA.
IT'S REALLY A PLEASURE FOR US TO
BE HERE TODAY.
I'M JOINED BY CHRISTINE HINDS
FROM OUR DIVISION OF PHARMACY.
SHE AND I WILL BE HAPPY TO
ANSWER ANY QUESTIONS FOR YOU AT
THE END AND BE WALKING YOU
THROUGH THE PARAMETERS OF THE
MEDICAID OFFERING OF ESSENTIAL

HEALTH BENEFITS.
I AM MELISSA HARRIS.
WE WORK WITH STATE PARTNERS ON ALMOST ALL FACETS OF MEDICAID BENEFITS SEARCHER.
MOST IMPORTANT FOR THIS CONVERSATION TODAY, TALKING ABOUT THE ALTERNATIVE BENEFIT PLAN OFFERED UNDER SECTION 1937.
WE IF WE GO TO THE FIRST SLIDE, PLEASE.
THE SLIDE DESCRIBES PROVISIONS OF THE FINAL REGULATION FOR MEDICAID ESSENTIAL HEALTH BENEFITS.
IT WAS PUBLISHED IN THE FEDERAL REGISTER IN THE MIDDLE OF JULY.
JULY 15th, I THINK.
AND IT HAS BEEN A GOOD USEFUL TOOL TO HAVE IN FINAL FORM SO WE CAN HAVE CONVERSATIONS WITH STATES WITHOUT FEELING LIKE THE LANDSCAPE IS SHIFTING FROM UNDERNEATH US.
SO TO HIT THE HIGHLIGHTS OF WHAT THAT REGULATION DID, IT FINALIZED REVISIONS TO WHAT HAD FORMERLY BEEN KNOWN AS THE BENCHMARK COVERAGE OPTION, AND WHAT IS NOW CALLED THE ALTERNATIVE BENEFIT PLAN.
AND WE HAD A CHANGE IN THE TERMINOLOGY SO WE COULD DIFFERENTIATE BENCHMARKS IN THE MEDICAID FROM BENCHMARKS IN THE COMMERCIAL MARKET CONTACTS.
SO OUR PROGRAM AUTHORIZED UNDER 1937 IS NOW CALMED THE ALTERNATIVE BENEFIT PLAN, AND THERE ARE A LOT OF SIMILARITIES BETWEEN THE SERVICES TO BE PROVIDED UNDER THIS AUTHORITY AND THE ESSENTIAL HEALTH BENEFITS TO BE PROVIDED IN THE COMMERCIAL MARKETS, AND THAT WAS INTENTIONAL IN THE STATUTE.
SO WE'LL REITERATE IN A BIT THE TEN SERVICES, OR THE TEN CATEGORIES, THAT COMPRISE THE CENTRAL HIL BENEFIT AND HOW MEDICAID DOES AND DOES NOT ALIGN WITH THE COMMERCIAL MARKET IN TERMS OF THE EHB GUIDANCE.
THE 1937 COVERAGE AUTHORITY WILL BE USED BY ALL STATES WHO ARE EXPANDING MEDICAID TO INDIVIDUALS IN A NEW ADULT GROUP

WITH INCOME NO GREATER THAN 133%
OF THE POVERTY LEVEL.
THIS MEANT THAT NOT EVERY STATE
HAD TO EXPAND THEIR MEDICAID
POPULATION.
THERE WOULD BE NO PENALTY IF
THEY DID KNOP.
SO IT MADE THE MEDICAID
EXPANSION CONVERSATION A
STATE-BY-STATE CONVERSATION.
WE ARE HAPPY TO REPORT THAT EVEN
EVEN -- EVEN AT THIS POINT IN
THE CALENDAR, STATES ARE STILL
MAKING DECISIONS TO GO FORWARD
WITH THE MEDICAID EXPANSION, AND
SO OUR NUMBERS ARE INCREASING,
STILL, IN TERMS OF NUMBER OF
STATES THAT ARE GOING FORWARD.
SO THE 1937 AUTHORITY WILL BE
USED IN ALL OF THOSE EXPANSIONS
DATES.
IT MUST BE THE COVERAGE OPTION
THAT IS USED TO INDIVIDUALS IN A
NEW ADULT GROUP.
STATES THAT THEIR OPTION CAN USE
THIS COVERAGE AUTHORITY FOR
INDIVIDUALS OUTSIDE OF THE
EXPANSION GROUP.
FOR EXAMPLE, THE STATE OF I'D
HOE HAS TRADITIONALLY OPERATED
AUMS ITS ENTIRE MEDICAID PROGRAM
UNDER THE SECTION AUTHORIZED IN
1937 AND EVEN THOUGH IDAHO IS
NOT EXPANDING, AT LEAST NOT IN
THE FORESEEABLE FUTURE, THEY ARE
GOING TO BE CONTINUING TO OFFER
THOSE 1937 AUTHORIZED BENEFITS
TO EXISTING INDIVIDUALS IN THEIR
MEDICAID PROGRAM.
SO IT REALLY DEPENDS ON THE
STATE IN TERMS OF THE SCOPE OF
INDIVIDUALS WHO WILL BE UNDER A
1937 PROGRAM, BUT IT IS THE
DEFAULT COVERAGE OPTION FOR
INDIVIDUALS IN THE EXPANSION
POPULATION.
LET ME GO
TO THE NEXT SLIDE, PLEASE.
SO SOME BACKGROUND ON WHAT THE
ALTERNATIVE BENEFIT PLAN IS, AND
IT IS LITERALLY A BENEFIT
PACKAGE THAT IS STOOD UP UNDER
SECTION 1937, THAT CAN STAND AS
AN ALTERNATIVE TO THE BENEFITS
STOOD UP IN A REGULAR MEDICAID
STATE PLAN.
THE MEDICAID STATE PLAN IS A

CONTRACT BETWEEN CMS AND THE
STATE MEDICAID AGENCY, AND IT
WALKS THROUGH THE NUTS, HOW
THEY'LL ADMINISTER THE PROGRAM.
IT HITS THE TOPICS OF
ELIGIBILITY.
WHO WAS OFFERED ENTRY INTO THE
MEDICAID PROGRAM?
THE BENEFITS THAT THEY WILL
RECEIVE.
THE PROVIDERS OF THE SERVICES.
ANY LIMITATIONS ON HOW THE
SERVICES ARE PROVIDED, IN TERMS
OF THE NUMBER OF VISITS OR A
DOLLAR AMOUNT.
HOW PROVIDERS ARE REIMBURSED.
WHETHER MANAGED CARE IS UTILIZED
OR NOT, AND IN A FEE FOR SERVICE
ENVIRONMENT, HOW SURVIVORS ARE
PAID ON A RATE OF METHODOLOGY
AND SOME QUALITY MEASURES, AND
SOME OTHER ADMINISTRATIVE AREAS.
THE TOPICS THAT WE DEAL WITH
MOST ARE THE BENEFITS PAGES, AND
WE WORK WITH THE STATE TO MAKE
SURE THE STATE PLAN IS A
COMPREHENSIVE DOCUMENT THAT
DESCRIBES WHAT IS BEING PROVIDED
TO THE BENEFICIARIES AND BY
WHOM.
SO THE ALTERNATIVE BENEFIT PLAN
IS MEANT TO BE A PACKAGE THAT
CAN LOOK LIKE THE SERVICES
PROVIDED IN THE TRADITIONAL
STATE PLAN, OR IT CAN BE
DIFFERENT.
THIS WAS TRUE BEFORE THE PASSAGE
OF THE AFFORDABLE CARE ACT AND
IS EVEN MORE TRUE NOW.
STATES HAVE A LOT OF FLEXIBILITY
IN TERMS OF DECIDING A BENEFIT
PACKAGE, BUT IN ALL CASES, THOSE
TEN ESSENTIAL HEALTH BENEFITS
MUST BE PROVIDED IN ANY BENEFIT
PACKAGE APPROVED UNDER SECTION
1937
1937 ALSO WAIVES A COUPLE OF
MEDICAID TENANTS THAT HOLD TRUE
IN THE REGULAR MEDICAID STATE
PLAN.
COMPREHENSIVE STABILITY AS
REQUIREMENTS THAT APPLY BUT DO
NOT APPLY IN SECTION 1937.
STATE WIDENESS MEANS THAT THE
PROGRAM IS, IT'S OFFERED ON A
STATE WIDE BASIS TO EVERYONE
REGARDLESS OF WHERE THEY ARE

LOCATED WITHIN A STATE'S BORDERS
AND
COMPARABILITY MEANS THE SERVICES
ARE PROVIDED IN THE SAME SCOPE
AND STRENGTH TO INDIVIDUALS
REGARDLESS OF HEALTH CONDITION.
THE FACT THAT THOSE TWO
PARAMETERS ARE WAIVED UNDER 1937
GIVES THE STATES A LOT OF
FLEXIBILITY TO CRAFT A DIFFERENT
BENEFIT PACKAGE, AND TO EVEN
PILOT TEST DIFFERENT BENEFIT
PACKAGES IN DIFFERENT AREAS OF
THE STATE, IF THEY FIND THAT
ATTRACTIVE.
THE REST OF 1937 REQUIRES THAT A
STATE IDENTIFY WHAT THE SERVICE
DELIVERY MECHANISM IS, WILL BE
SERVICES BE PROVIDED IN SECRET
SERVICE OR MANAGED CARE, AND
WHAT KIND OF COST SHARING
REQUIREMENTS ARE GOING TO BE
UTILIZED FOR INDIVIDUALS UNDER
1937 AUTHORIZED PROGRAM.
WE ARE ALREADY ON THE NEXT
SLIDE.
THAT REITERATES THE TEN
ESSENTIAL HEALTH BENEFITS.
THE EXACT SAME BENEFITS AS USED
IN THE COMMERCIAL MARKET, AND
THAT WOULD BE FACETED A STATUTE
TO INDICATE THAT THE COVER THE
BENEFITS PROVIDED TO INDIVIDUALS
IN THIS NEW EXPANSION GROUP
WOULD BE THE SAME AS THOSE
BENEFITS PROVIDED IN THE
COMMERCIAL MARKETPLACE, AND THE
EXCHANGES.
WE CAN GO TO THE NEXT SLIDE,
PLEASE.
AS WE HAVE TECHNICAL ASSISTANCE
CONVERSATIONS WITH OUR STATE
MEDICAID PARTNERS WE ARE WALKING
THEM THROUGH A SEQUENCE OF
DECISIONS THAT STATES WILL NEED
TO MAKE AS THEY DESIGN THEIR
ALTERNATIVE BENEFIT PLAN.
AND WE ALWAYS ASK THE STATE TO
START OUT WITH WHAT THEIR
OVERALL JAT STRATEGY IS IN TERMS
OF A FINAL PRODUCT, THAT WE
WOULD BE APPROVING IN THEIR
STATE PLAN AMENDMENT.
A LOT OF STATES HAVE AN END GOAL
OF HAVING A BENEFIT PACKAGE IN
THEIR ALTERNATIVE BENEFIT PLAN
THAN IS IN FACT IN COMPLETE

ALIGNMENT WITH THEIR REGULAR
STATE PLAN.
THIS COULD BE TRUE FOR A COUPLE
OF REASONS.
IT COULD BE ADMINISTRATIVELY
SIMPLER FOR THE STATE TO
ADMINISTER A STATE PACKAGE AND
THE STATE MIGHT FEEL
SUBSTANTIVELY THEY WANT TO
PROVIDE THE SAME BENEFITS TO
INDIVIDUALS REGARDLESS OF
INCOME.
OTHER STATES MIGHT WANT TO FOCUS
ON A COMMERCIALLY DERIVED
BENEFIT PACKAGE OR INDIVIDUALS
IN THE NEW ADULT GROUP, AND ARE
FINE WITH OPERATING TWO
DIFFERENT BENEFIT PACKAGES.
ONE TO THE EXPANSION POPULATION.
ONE TO OTHER INDIVIDUALS IN THE
STATE'S MEDICAID PROGRAM.
SO WE ALWAYS FIND OUT WHERE A
STATE IS IN THOSE DECISIONS.
THAT STRATEGY WILL THEN GUIDE
OUR ADVICE TO A STAY HOW TO
DERIVE THEIR BENEFITS.
BUT IN ALL CASES A STATE HAS TO
BE AWARE OF TWO DIFFERENT MENUS
OF BENEFIT PACKAGES.
THE FIRST LIST COMES FROM
SECTION 1937, AND IT IS THOSE
FOUR OPTIONS THAT YOU SEE ON THE
SCREEN.
1937 MENTIONS THREE COMMERCIAL
OPTIONS THAT A STATE CAN CHOOSE.
ONE BEING THE BENEFIT PACKAGES
PROVIDED TO FEDERAL EMPLOYEES.
THE OTHER BEING THE BENEFIT
PACKAGE PROVIDED TO EMPLOYEES OF
THE STATE IN QUESTION, AND THE
THIRD BEING THE BENEFIT PACKAGE
AUTHORIZED BY THE LARGEST
COMMERCIAL NON-MEDICAID HMO.
THE FOURTH OPTION IN 1937 IS
KIND OF THE OTHER CATEGORY, AND
IT'S CALLED SECRETARY COVERAGE,
MEANING A STATE CAN COME TO CMS
AND SAY I WANT TO CRAFT MY OWN
BENEFIT PACKAGE THAT DOESN'T
LOOK IDENTICAL TO ANY OF THOSE
THREE COMMERCIAL PRODUCTS.
WE CAN THEN APPROVE THAT
COVERAGE UNDER THE SECRETARY
APPROVED AUTHORITY IN 1937.
>>> THE SECOND LIST OF BENEFIT
PLANS A STATE HAS TO CONSIDER
ARE THOSE SAME TEN COMMERCIAL

PLANS THAT HAVE BEEN AUTHORIZED
FOR USE IN THE MARKETPLACE FOR
DEFINING ESSENTIAL HEALTH
BENEFITS.
THERE ARE A LOT OF SIMILARITIES
BETWEEN THIS LIST OF BENEFIT
PLANS AND THE BENEFIT PLANS
AUTHORIZED IN SECTION 1937, BUT
THEY'RE NOT IDENTICAL.
THE NEXT SLIDE WALKS THROUGH
WHAT THOSE COMMERCIAL PLANS ARE.
THAT CAN BE USED TO DEFINE
ESSENTIAL HEALTH BENEFITS, AND
THEY ARE ANY OF THE THREE
LARGEST SMALL GROUP PLANS BY
ENROLLMENT WHICH IS DIFFERENT
FROM THE LIST FOUND IN 1937, AND
THEN WE GET INTO THE
SIMILARITIES, THE EXTENT PLANS,
THE FEDERAL EMPLOYEE PLANS AND
LARGEST COMMERCIAL NON-EDUCATED
HMO.
NOTICE THERE IS NO SECRETARY
COVERAGE HERE.
PARTIAL ALIGNMENT BUT NOT
COMPLETE ALIGNMENT BETWEEN
AUTHORIZE IN 1937 AND THE
AUTHORITIES IN THE COMMERCIAL
PLAN TO DEFINE ESSENTIAL HEALTH
BENEFITS.
SO IN OUR CONVERSATIONS WITH
STATES, WE'RE MAKING THEM WAERP
THE LIST ARE SIMILAR, NOT
IDENTICAL AND WALKING THEM
THROUGH WHAT'S IN THEIR BEST
INTERESTS IN PICKING A PLAN TO
DEFINE FEDERAL HEALTH BENEFITS
AND A COLLECTION OPTION IN 1937.
THE MA JOMPTY OF STATES, MOST
STATES, ARE FOCUSING ON THE
SECRETARY APPROVED COVERAGE
AUTHORITY IN 1937, WHICH ALLOWS
FOR MAXIMUM FLEXIBILITY FOR A
STATE TO DEFINE A BENEFIT
PACKAGE, AND THIS IS NECESSARY
FOR THOSE STATES WHO, AGAIN,
WANT TO HAVE AN ALTERNATIVE
BENEFIT PLAN THAT INCLUDES ALL
THE SERVICES IN THE MEDICAID
STATE PLAN.
ASIDE FROM THE ESSENTIAL HEALTH
BENEFITS.
TO THE EXTENT THAT THE STATE
SELECTED A PLAN THAT IS BOTH A
1937 COVERAGE OPTION AND IS AN
OPTION FOR THE DEFINES ESSENTIAL
HEALTH BENEFITS, THERE REALLY

NOT ENCRAFTING THEIR BENEFIT
PACK.
.
A PLAN FOR THIS THAT IS NOT ONE
OF THE 193'S COVERAGE OPTIONS,
WE NEED TO MARRY THOSE TWO, AND
FIGURE OUT WHAT THAT SPITS OUT
IN TERMS A BENEFIT PACKAGE AND
HOW CLOSE DOES THAT GET THE
STATE TO THE BENEFIT PACKAGE
THEY ULTIMATELY WANT TO PROVIDE.
WE CAN GO TO THE NEXT SLIDE,
PLEASE.
THE SUBSTITUTION POLICY I
SPECIFICALLY WANTED TO FOCUS ON
TODAY, BECAUSE IT IS VERY
IMPORTANT AND USEFUL FOR STATES
THAT WANT TO ALIGN THEIR BENEFIT
PACKAGES BETWEEN WHAT THEY'RE
COVERING IN THE ABP FOR THE
EXPANSION GROUP AND WHAT THEY'RE
COVERING IN THEIR TRADITIONAL
STATE PLAN.
SUBSTITUTION INDICATES THAT A
STATE CAN ELECT NOT TO COVER
SOMETHING THAT THE COMMERCIAL
PLAN OFFERS, AND INSTEAD OFFERS
SOMETHING THAT IS ACTUARIALLY
EQUIVALENT.
I SHOULD BACK UP HERE AND SAY
THE FIRST ACTIVITY A STATE NEEDS
TO DO WHEN THEY ARE TRYING TO
STOCK THEIR ESSENTIAL HEALTH
BENEFITS TO BE OFFERED UNDER THE
ALTERNATIVE BENEFIT PLAN, MAP
THE SPECIFIC SERVICES IN THE
COMMERCIAL THEY'VE PLAN SELECTED
TO DEFINE EHB TO THE TEN EHB
CATEGORIES.
SAY THEY SELECTED ONE OF THE
FEDERAL EMPLOYEE PLANS TO DEFINE
EHBs.
THEY WOULD LOOK AT ALL SERVICES
THE FEDERAL EMPLOYEE PLAN COVERS
AND MAP EACH TO ONE OF THE TEN
ESSENTIAL HEALTH BENEFIT
CATEGORIES.
MATCH IT TO HOSPITALIZATION
SERVICES.
MAP FEDERAL EMPLOYEE PLAN
SERVICES TO MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES.
ALL THE WITH DOWN THE LIST OF
THE TEN ESSENTIAL HEALTH
BENEFITS.
THAT, THEN IS A STARTING POINT
FOR THE STATE TO SAY THIS IS MY

BENEFIT PACKAGE THAT WILL
PROVIDE ESSENTIAL HEALTH
BENEFITS.
THE STATE THEN COMPARES THAT TO
WHERE THEY WANT TO END UP AND
MOST LIKELY WILL BE COMPARING
THAT TO THEIR MEDICAID STATE
PLAN.
IT COULD BE THAT THE COMMERCIAL
PLAN OFFERS SOMETHING THAT THE
MEDICAID STATE PLAN DOES NOT.
THE STATE CAN THEN USE THE
SUBSTITUTION POLICY THAT'S
OUTLINED HERE TO REMOVE THE
SERVICE THAT THE COMMERCIAL PLAN
OFFERED, AND IN ITS PLACE OFFER
SOMETHING THAT IS ACTUARIALLY
EQUIVALENT, AS LONG AS IT MAPS
TO THE SAME EHB CATEGORY.
SO IF THE STATE TAKES OUT THAT
THE FEDERAL EMPLOYEE PLAN IN OUR
EXAMPLE, MAPS TO AMBULATORY
CARE, A STATE WOULD PUT
IN-THE-PLACE UNDER THE
AMBULATORY CARE CATEGORY A
SERVICE THAT WAS ACTUALLY
ACTUARIALLY EQUIPMENT TO THE
SERVICE IT REMOVED.
SO STATES ARE FINDING THIS
RELATIVE HI USEFUL IN HELPING
THEIR ALIGNMENT GOALS.
SOMETIMES THEY ARE INSERTING
STATE PLAN SERVICES, THAT THE
COMMERCIAL PLAN DOES NOT COVER,
AND THEY’RE FINDING OUT IT IS
ANOTHER PASS FOR THEM TO EASILY
END UP WITH A BENEFIT PLAN IN
ALIGNMENT WITH THEIR STATE
MEDICAID PLAN.
WE CAN GO
TO THE NEXT SLIDE, PLEASE.
THE GOALS OF MEDICAID'S OFFERING
OF ESSENTIAL HEALTH BENEFITS WAS
TO PRIMARILY ALIGN HOW THE EPLS
WILL BE IN THE MARKET.
A COUPLE DESERVE A SPECIFIC MEDICAID
CONVERSATION WOUND GEL TO THOSE.
ONE IS MEDICAID DOES NOT HAVE TO
SELECT THE SAME COMMERCIAL PLAN
TO DEFINE ESSENTIAL HEALTH
BENEFITS AS HAVE BEEN SELECTED
IN THE COMMERCIAL MARKET.
WE ARE USING THE SAME LIST OF
TEN COMMERCIAL PLANS TO DEFINE
EHBs BUT IT DOESN'T HAVE TO BE
THE SAME, EXACT PLAN TO DEFINE
EHBs FOR THE COMMERCIAL MARKET

OR FOR MEDICAID, AND BECAUSE OF THE FLEXIBILITY IN SECTION 1937, A STATE CAN EVEN CHOOSE TO USE MORE THAN ONE COMMERCIAL PLAN TO DEFINE EHBs IF THEY ARE CHOOSING TO TARGET POPULATIONS WITHIN 1937, AND THAT TARGETING FLEXIBILITY IS AVAILABLE BECAUSE OF THE COMPARABILITY SECTION IN 1987

STATES STILL HAVE TO COVER EVERYONE IN THE NEW ADULT GROUP IN THEIR STATE, BUT COULD CHOOSE TO DO IT BY OFFERING DIFFERENT SEGMENTS OF THE NEW ADULT GROUP. AND A DIFFERENT BENEFITS PACKAGE.

IF THEY'RE DOING THAT, THEY CAN USE DIFFERENT COMMERCIAL PLANS TO DEFINE EHBs FOR EACH OF THOSE DIFFERENT BENEFIT PACKAGES.

NEXT SLIDE, PLEASE.

SO THE FIRST ESSENTIAL HEALTH BENEFIT CATEGORY THAT DESERVES SOME SPECIAL MENTION IS PRESCRIPTION DRUG, AND I WILL HIT THE HIGH POINTS OF THIS AND THEN CHRISTINE HINDS WILL BE AVAILABLE TO ANSWER ANY QUESTIONS.

WE KNOW THIS IS PARTICULARLY IMPORTANT TO AN AUDIENCE OF RYAN WHITE GRANTEES.

AS WITH ALL OF THE ESSENTIAL HEALTH BENEFIT CATEGORIES, THE COMMERCIAL PLAN IS SERVING TO DEFINE THE AMOUNT, DURATION AND SCOPE OF THE PRESCRIPTION DRUG ESSENTIAL HEALTH BENEFIT.

SO IT'S THE SAME STRENGTH OF BENEFIT IN MEDICAID THAT IT WILL BE IN THE COMMERCIAL MARKET, AT LEAST AS THE FOUNDATION.

SO AGAIN, THE SCOPE IS THE GREATER OF ONE DRUG IN EVERY USB CATEGORY AND CLASS OR THE SAME NUMBER OF DRUGS IN EACH CATEGORY AND CLASS AS THE PLAN SELECTED AT THE COMMERCIAL PLAN TO DEFINE EHBs.

YOU CAN GO ABOVE THAT THRESHOLD NAP IS THE FLOOR OF COVERAGE, BUT STATES CAN EXCEED THAT COVERAGE, AND IN THE CASE OF THE MANY STATES WHO ARE WANTING TO ALIGN THEIR ALTERNATIVE BENEFIT PLAN WITH THE MEDICAID STATE

PLAN, THEY, IN FACT, ARE GOING ABOUT THAT THRESHOLD AND USING THE SAME NUMBER AND TYPES OF DRUGS IN THE ALTERNATIVE BENEFIT PLAN AS IS CURRENTLY BEING USED IN THEIR STATE'S MEDICAID PROGRAM.
BUT EVEN WITHIN THE COMMERCIAL MARKET STANDARDS, THE STATE MUST INCLUDE SUFFICIENT DRUG COVERAGE TO REFLECT THE STANDARDS THAT ARE USED IN THE COMMERCIAL PLANS TO DEFINE EHBs, AND THEY MUST HAVE PROCEDURES IN PLACE TO ALLOW A BENEFICIARY TO REQUEST AND GAIN ACCESS TO CLINICALLY APPROPRIATE DRUGS THAT ARE NOT LISTED IN THAT COMMERCIAL PLAN.
AND THEN THE LINKAGE BETWEEN THE PRESCRIPTION DRUG ESSENTIAL HEALTH BENEFIT AND THE MEDICAID REBATE PROVISIONS AT 1927 IS FOUND IN ITS FINAL BULLET.
SO ANY DRUG THAT IS COVERED BY THE ALTERNATIVE BENEFIT PLAN THEN MUST MEET ALL 1927 REBATES PROVISIONS.
>> AGAIN, WE'RE HAPPY TO FOCUS ON THAT A LITTLE BIT AT THE Q&A SESSION.
NEXT SLIDE, PLEASE.
WE'LL SPEND JUST A MINUTE ON HABILITATIVE SERVICES.
THIS IS THE BENEFIT THAT TENDS TO STICK OUT AS NOT COVERED BY MOST MEDICAID PROGRAMS TODAY.
THE FINAL REGULATIONS THAT I MENTIONED A BIT AGO SPENT A LOT OF TIME DESCRIBING WHAT HABILITATIVE SERVICES COULD LOOK LIKE, BUT IN THE END DELEGATES ALSO ALL OF THE FLEXIBILITY FOR DEFINES THESE SERVICES TO THE STATES.
THERE CAN BE SERVICES IN THE COMMERCIAL PLAN, TO LIKEN TO DEFINE EHBs THAT COULD BE CONSIDERED HABILITATIVE.
IF THAT'S THE CASE, THE STATE NEEDS TO PROVIDE THOSE SERVICES OR OFFER SOMETHING IN ITS PLACE IN THIS SERVICES CATEGORY.
I WILL TELL YOU MANY STATES ARE LOOKING AT THE PHYSICAL THERAPY, OCCUPATIONAL, SPEECH THERAPY AND LOOKING TO PROVIDE THEM WITH A CHARACTERIZATION OF

PROMOTION-OF-PROMOTING SKILL
ACQUISITION AND MAINTENANCE.
NOT JUST SKILL RESTORATION.
SOME STATES FIND THAT IS
ATTRACTIVE TO HAVE AS THEIR
HABILITATIVE SERVICES AND OTHERS
ARE LOOKING FOR A DIFFERENT
SCOPE.
WE VENTURED A GUESS OF
SIGNIFICANT VARIATION IN THIS
CATEGORY ACROSS THE STATES,
EITHER BECAUSE OF DIFFERENT
SERVICES OFFERED IN THE
COMMERCIAL PLANS, OR DIFFERENT
STATE STRATEGIES FOR DEFINING
THEMSELVES.
THUS, THE EHB CATEGORY.
NEXT SLIDE, PLEASE.
PREVENTIVE SERVICES AS AN
ESSENTIAL HEALTH BENEFIT
CATEGORY IS REALLY THE ONE EHB
CATEGORY THAT IS PRESCRIPTIVELY
DEFINED AT THE FEDERAL LEVEL.
THERE WAS A -- A SECTION OF THE
AFFORDABLE CARE ACT THAT
MODIFIED THE PUBLIC HEALTH
SERVICES ACT TO DEFINE
PREVENTIVE SERVICES AS ALL OF
THE SERVICES WITHIN A GRADE A OR
B RECOMMENDATION FROM THE U.S.
PREVENTIVE SERVICES TASK FORCE.
ALL OF THE VACCINES RECOMMENDED
BY ASAP.
ALL OF THE RECOMMEND MATIONS
FROM WOMEN'S PREVENTIVE HEALTH
AND ALL OF THE HRSA BRIGHT AND
FUTURES RECOMMENDED SERVICES.
THOSE SERVICES COMPRISED
PREVENTIVE SERVICES ESSENTIAL
HEALTH BENEFIT CATEGORY FOR BOTH
THE COMMERCIAL MARKET AND MORE
MEDICAID PAP STATE CAN CERTAINLY
DO MORE THAN THAT SCOPE OF
SERVICES, BUT THEY HAVE TO
INCLUDE THOSE DISCREET SERVICES
IN THE FREECHBTIVE CATEGORY, AND
THERE IS A PROHIBITION ON COST
SHARING FOR THOSE SERVICES BOTH
IN THE COMMERCIAL MARKET AND FOR
MEDICAID.
NEXT SLIDE, PLEASE.
THIS TOPIC OF MEDICAL FRAILTY IS
OF PRIMARY IMPORTANCE TO STATES
AND WE TALK ABOUT IT IN ALMOST
EVERY CONVERSATION WE HAVE WITH
THEM ABOUT STANDING UP AN
ALTERNATIVE BENEFIT PLAN.

THERE ARE SEVERAL PROVISIONS OF
STATUTE THAT DEAL WITH
INDIVIDUALS WHO CANNOT BE
MANDATED INTO AN ALTERNATIVE
BENEFIT PLAN.
SYSTEMS FROM CONGRESS' INITIAL
IMPLEMENTATION OF SECTION 1937,
WHICH STARTED IN 2005.
'S IN A REDUCTION ACT, AND IT
WAS DETERMINED THAT THERE WERE
SOME INDIVIDUALS FOR WHOM A
COMMERCIALLY DRIVEN BENEFIT
PACKAGE MIGHT NOT BE SUFFICIENT.
AND MEDICALLY FRAIL WAS ONE OF
THOSE CATEGORIES.
I WILL ADMIT IT'S VERY
UNFORTUNATE PHRASING.
WE DON'T TYPICALLY USE THE TERM
\MEDICAL FRAILTY\ IN TODAY'S
VERNACULAR SO IT'S USED IN OUR
REGULATION BECAUSE IT IS WHAT IS
IN THE STATUTE BUT CERTAINLY
ENCOURAGE STATES TO CALL THIS,
THIS CONVERSATION SOMETHING
COMPLETELY DIFFERENT.
SO WHAT THIS MEANS FOR STATES
WHO ARE EXPANDING MEDICAID IS A
CONTEXT OF SECTION 1937, IT'S A
LITTLE DIFFERENT, BECAUSE
EVERYONE IN THE NEW ADULT GROUP
MUST BE SERVED IN A, AN
ALTERNATIVE BENEFIT PLAN UNDER
1937
SO WHAT THIS MEANS IS THAT
WITHIN THE CONTEXT OF 1937,
INDIVIDUALS WHO ARE MEDICALLY
FRAIL MUST BE GIVEN A CHOICE OF
BENEFIT PACKAGES.
ONE WOULD BE THE BENEFIT PACKAGE
THAT STOOD UP AS THE ALTERNATIVE
BENEFIT PLAN, INCLUDING
ESSENTIAL HEALTH BENEFITS, AND
INCLUDING THE OTHER REQUIREMENTS
OF 1937.
THE OTHER BENEFIT PACKAGE THAT
INDIVIDUALS WHO ARE MED CLI
FRAIL MUST HAVE A CHOICE TO
RECEIVE.
IT MIRRORS WHAT'S IN THE
STATES' -- AND WE ARE SPENDING A
LOT OF TIME MAKING SURE STATES
UNDERSTAND THAT RESPONSIBILITY.
AND TO THE EX-TENT THERE IS
COMPLETE ALIGNMENT BETWEEN THE
BENEFIT PLAN AND STATE PLAN
THERE IS NO NEED TO HAVE ANY
KIND OF BENEFIT CHOICE, BECAUSE

WE'RE TALKING ABOUT AN IDENTICAL BENEFIT.
IF THERE ARE DIFFERENCES BETWEEN THE ALTERNATIVE BENEFIT PLAN AND THE STATE PLAN, THEN A STATE MUST HAVE A PROCESS TO IDENTIFY INDIVIDUALS WHO ARE MEDICALLY FRAIL AND GIVE THEM A CHOICE OF BENEFITS PLAN AND MAKE SURE THEY UNDERSTAND WHAT SERVICES ARE INCLUDED IN EACH PROPOSAL.
FOR INDIVIDUALS WHO ARE, WHO HAVE HIV OR AIDS IT IS NOT A GENERIC ANSWER AS TO WHETHER THEY ARE MEDICALLY FRAIL.
OUR REGULATORY DEFINITION INDICATES THAT THE MEDICALLY FRAIL CRITERIA ARE INDIVIDUALS WHO NEED ASSISTANCE WITH ONE OR MORE ACTIVITIES OF DAILY LIVING.
INDIVIDUALS WHO HAVE A CHRONIC SUBSTANCE USE ISSUE.
A CHRONIC MENTAL HEALTH ISSUE.
PHYSICAL DISABILITY.
INTELLECTUAL DISABILITY.
A FORMAL DISABILITY BY THE SOCIAL SECURITY ADMINISTRATION, BUT IT'S A VERY BROAD -- SO SOMEONE WHO HAS HIV OR AIDS COULD MEET THAT CRITERIA.
IT IS NOT A DEFAULT DETERMINATION, THOUGH, BECAUSE INDIVIDUALS WITH THAT SAME DISEASE COULD HAVE A VERY DIFFERENT PRESENTATION, AND SO THAT THE ANSWER IS DIFFERENT INDIVIDUALLY, IN TERMS OF WHETHER OR NOT THEY WOULD BE CONSIDERED MEDICALLY FRAIL.
THE NEXT SLIDE I THINK WE'LL SKIP OVER QUICKLY, CONTAINS GENERAL 1937 REQUIREMENTS WHICH INCLUDES THE REQUIREMENT ANYONE UNDER AGE 21 IS PROTECTED BY THE PROVISIONS, ENSURING PROVISION OF ANY NECESSARY SERVICE, MENTAL HEALTH PARITY IS REQUIRED IN AN ALTERNATIVE BENEFIT PLAN AS IT IS IN THE COMMERCIAL AREA AND MUST BE INCLUDED ON TOP OF EHBs AND THEY ARE SERVICES PROVIDED BY A FEDERALLY QUALIFIED HEALTH CENTER OR WORLD HEALTH CLINIC.
NOUN EMERGENCY MEDICAL TRANSPORTATION AND FAMILY PLANNING SERVICES AND SUPPLIES.
THE NEXT SLIDE INDICATES THAT AS

WE PUBLISHED THE REGULATION IN THE SUMMER OF 2013, WE KNEW THAT WE WERE JUST A FEW SHORT MONTHS AWAY FROM MOST STATES ANTICIPATING GO LIVE DATES OF JANUARY 1, TO 142014.
THIS WAS A STATEMENT THAT WE EXPECT STATES, THE GOLD STARNT, STATEMENT, OF COURSE, THEY ARE COMPLETELY READY TO EXPAND ON JANUARY 21, BUT WE UNDERSTAND SOME MIGHT NOT BE IN TERMS OF HAVING EVERY I DOTTED AND EVERY T CROSSED.
IT IS OUR GOAL TO WORK WITH STATES TO MAKE SURE THE JANUARY OFFERINGS AS ROBUST AS POSSIBLE AND PROVIDES THE SERVICES THAT ARE IN THE STATE'S ALTERNATIVE BENEFIT PLAN.
I THINK IT REMAINS TO BE SEEN FOR ALL OF US EXACTLY WHAT WILL HAPPEN ON JANUARY 1, BUT IT IS OUR FIRM COMMITMENT TO MAKE SURE STATES HAVE A ROBUST BENEFIT PACKAGE STOOD UP AT THAT TIME.
AND THEN THE FINAL SLIDE IS A WORD ON A CHANGE WE MADE TO THE PREVENTIVE SERVICES THAT APPLY NOT JUST TO INDIVIDUALS IN THE NEWS EXPANSION GROUP BUT INDIVIDUALS IN THE MEDICAID PROGRAM AT LARGE.
WE ALIGNED A REGULATORY LANGUAGE WITH WHAT HAD BEEN THE STATUTE ALL ALONG, AND BROADENED THE SCOPE OF PRACTITIONERS WHO COULD DELIVER THE SERVICES.
NOT ONLY BY A PHYSICIAN OR OTHER LICENSED PRACTITIONER.
NOW JUST RECOMMENDED BY THOSE INDIVIDUALS BUT CAN BE PROVIDED BY ANYONE AS HE OR SHE SO CHOOSES.
THERE IS ALSO A SEPARATE PROVISION OF THE AFFORDABLE CARE ACT THAT SAYS STATES CAN AMEND THEIR PREVENTIVE SERVICES SECTION OF THEIR REGULAR MEDICAID STATE PLAN, AND AS LONG AS IT INCLUDES THOSE SAME A AND B SERVICES FROM A U.S. SERVICES
TRAFFIC FORCE AND THE SAME RECOMMENDED VACCINES, AT NO COST SHARING, STATE WILL BE ELIGIBLE FOR 1 PERCENTAGE POINT OF

ADDITIONAL FEDERAL MATCH.
SO WE ARE MAKING SURE STATES ARE AWARE OF THAT, AND HAVE APPROVED A COUPLE OF THOSE B PLANS.
SO LET ME STOP HERE AND WE ARE HAPPY TO ANSWER QUESTIONS AT THE END, BUT AT THIS POINT I WILL TURN IT BACK OVER TO YOLANDA.
THANKS.
>> THANKS, MELISSA.
OKAY.
I WAS INDICATING, AN OFFICE OF EVALUATION, AND I WANT TO SPEND THE NEXT SEVERAL SLIDES AND THE CONCLUSION OF THIS PRESENTATION KIND OF TYING WHAT WE'VE HEARD FROM CCIIO, SUCH AS HEALTH BENEFITS OFFERED IN PRIVATE HEALTH PLANS AND MEDICAID, AND WHAT THAT MEANS FOR THE RYAN WHITE HIV PROGRAM.
JUST A REMINDER.
EVEN WITH THE AFFORDABLE CARE ACT, THE RYAN WHITE HV AIDS PROGRAM IS STILL THE CARE OF LAST RESORT.
THIS MEANS THAT RYAN WHITE FUNDS MAY NOT BE USED FOR ANY ITEM OR SERVICE TO THE EXTEND THAT HAS BEEN MADE OR PAYMENT EXPECTED TO BE MADE BY ANOTHER PAYMENT SOURCE.
THE GRANTEES AND SUBGRANTEES ARE EXPECTED TO VIGOROUSLY PURSUE ENROLLMENT IN ALL OTHER FUNDING SOURCES INCLUDING MEDICAID, CHIP, MEDICARE, HEALTH INSURANCE, PRIVATE HEALTH INSURANCE INCLUDING PLANS IN THE MARKETPLACE.
THIS IS REALLY TO EXTEND THE FINITE GRANT RESOURCES TO NEW CLIENTS WHO ARE IN NEED OF SERVICES.
ONCE A CLIENT IS ENROLLED IN MEDICAID OR A PRIVATE HEALTH PLAN, THE RYAN WHITE HIV AID PROGRAMS FUND MAY ONLY BE USED TO PAY FOR ITEMS AND SERVICES NOT COVERED OR PARTIALLY COVERED BY MEDICAID OR THE CLIENT'S PRIVATE HEALTH PLAN.
WE'VE RECENTLY ISSUED A COUPLE POLICY NOTICES ON THE ACA WEBSITE.
AND I'VE PROVIDED A LINK ON THE SLIDE HERE SO YOU CAN DIRECTLY

REFER TO POLICY CLARIFICATION
NOTICE 1301 FROM MEDICAID.
ELIGIBLE CLIENTS AND THEN 1304
FOR CLIENTS WHO WOULD BE
ELIGIBLE FOR PRIVATE INCLUDING
THOSE OFFERED IN THE
MARKETPLACE.
ANOTHER REMINDER THAT RYAN WHITE
FUNDS MAY ALSO BE USED TO COVER
THE COST OF PREMIUM,
DEDUCTIBLES, CO-PAYMENTS AND
OTHER COST SHARINGS FROM
MEDICAID AND PRIVATE HEALTH
INSURANCE CLIENTS AND THIS
INFORMATION COULD ALSO BE FILLED
IN RECENTLY RELEASED POLICY
NOTICES 1305 AND 1306 AND ONCE
AGAIN THOSE ARE ALL IN THE
AFFORDABLE CARE ACT WEBSITE WE
HAVE AND WE CAN PROVIDE IT HERE
ON THE SLIDE.
OKAY.
SO AS YOU'VE HEARD FROM OUR
PRESENTERS FROM CMCS, THERE ARE
A LOT OF OPTIONS AVAILABLE TO
THE STATES, BOTH IN THE PRIVATE
HEALTH INSURANCE WORLD AND IN
MEDICAID IN TERMS OF ESSENTIAL
OFFERINGS.
SO WE JUST WANTED TO HIGHLIGHT
TO YOU THAT THERE IS A LITTLE
BIT OF OVERLAP IN TERMS OF RYAN
WHITE, HIV-AIDS PROGRAM CORE
MEDICAL, AND SUPPORT SERVICES
WITH THE ESSENTIAL HEALTH
BENEFITS.
SO SOME RYAN WHITE CORE MEDICAL
SERVICES SUCH AS PRESCRIPTION
DRUG, MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES, AND
EVEN SOME OF THE RYAN WHITE
SUPPORT SERVICES IMPLICATE
REHABILITATION SERVICES WILL BE
COVERED BENEFITS OF THE PRIVATE
HEALTH PLANS OF ALTERNATIVES
PLANS.
HOW MUCH, IT'S IMPORTANT TO
REMEMBER THAT THE SCOPE OF
COVERAGE VARIES BY PLAN.
IN ADDITION, SUBRYAN WHITE CORE
MEDICAL AND MANY OF THE SUPPORT
CORE SERVICES SUCH AS ADULT ORAL
HEALTH CARE OR TREATMENT
ADHERING TO COUNSELING,
OUTREACH, TRANSPORTATION, ET
CETERA, MAY NOT ACTUALLY BE
COVERED BENEFITS UNDER THE

HEALTH PLANS OF MEDICAID AND
BENEFIT PLAN.
SO IT'S REALLY IMPORTANT TO
RECOGNIZE THAT THERE WILL BE A
VARIATION ACROSS STATES AND
ACROSS PLANS FOR CLIENTS THAT
ARE GOING TO BE ENROLLING EITHER
AS A PRIVATE HEALTH PLAN OR THE
MEDICAID, ESPECIALLY GOOD GOING
THROUGH ALTERNATIVE MEDICAID
PLAN.
BE AWARE OF THE PLANS AND
ALTERNATIVE BENEFIT PLAN SO THAT
YOU CAN HELP IDENTIFY, HELP
CLIENTS IDENTIFY AND ENROLL IN
HEALTH COVERAGE THAT BEST
MEETS INDIVIDUAL HIV CARE
NEEDS.
IT'S ALSO IMPORTANT TO RECOMMEND
THAT RYAN WHITE FUNDS MAY BE
USED TO PAY FOR ITEMS OR
SERVICES NOT COVERED OR
PARTIALLY COVERED BY MEDICAID OR
THE CLIENT'S PRIVATE HEALTH
INSURANCE.
RYAN WHITE WILL PROVIDE THAT
SUPPORT FOR CLIENTS MOVING INTO
HEALTH INSURANCE COVERAGE.
SO WHERE YOU CAN ACTUALLY START
IN TERMS OF LEARNING ABOUT THAT,
THE DIFFERENT ESSENTIAL HEALTH
BENEFIT PACKAGES, THERE'S NO
QUESTION I THINK WE HEAR EVERY
ONCE IN A WHILE, AND I PROVIDED
A COUPLE LINKS HERE.
SO AS LISA AND HER COLLEAGUES
HAD MENTIONED, CCIIO HAS A GREAT
WEBSITE AND RESOURCES.
NOT ONLY A PLAN OF REGULATION
THERE, BUT THEY ALSO HAVE A
WEBSITE WHERE YOU CAN ACTUALLY
GO AND FIND THE STATE IN WHICH
YOU LIVE AND SEE WHAT THE
BENCHMARK PLAN IS BEING OFFERED
IN THAT STATE, AND THEY HAVE
GREAT -- LIKE A LOADABLE PDA.
YOU CAN ACTUALLY SEE DIFFERENT
TYPES OF BENEFITS AND WHATNOT
OFFERED IN THEIR PLAN, AND
PROVIDED A LINK TO THAT SITE ON
THIS SLIDE, AND THERE SHOULD BE
A LINK TO THAT ON THE MODULE AS
WELL.
TMCS, AN INITIATIVE THEY'LL BE
POSTING INFORMATION ABOUT THE
STATE PLAN FOR THE MEDICAID
ALTERNATIVE BENEFIT PLAN.

AND THAT'S ALL GOING TO BE
HOUSED ON THE MEDICAID.GOV SITE.
CHECK IT OUT.
THERE SHOULD BE UPDATES AS THEY
GET THEM ON THE BENEFIT PLANS
FOR THE STATE.
OKAY.
SO WE'VE INCLUDED THIS AGAIN
FROM THE BEGINNING OF THE
PRESENTATION, WHERE WE JUST
WANTED TO REITERATE OR RECAP THE
DIFFERENT HEALTH COVERAGE
OPTIONS AVAILABLE FOR RYAN WHITE
CLIENTS MOVING INTO 2014.
SO MANY PEOPLE LIVING WITH HIV
OR AIDS WILL BECOME ELIGIBLE FOR
MEDICAID WITHOUT HAVING TO MEET
THE DISABILITY ELIGIBILITY
CRITERIA AND STATES IMP MA KATE
THIS.
AND MANY LIVING WITH HIV WILL
BECOME NEWLY ELIGIBLE FOR
PRIVATE HEALTH INSURANCE,
ESPECIALLY SINCE THE AFFORDABLE
CARE ACT ACTUALLY PROHIBITS
HEALTH INSURANCE FROM DENYING
COVERAGE TO INDIVIDUALS BASED ON
HEALTH STATUS OR PRE-EXISTING
CONDITION.
SO PEOPLE LIVING WITH HIV OR
AIDS WILL GAIN PRIVATE INSURANCE
EITHER THEY'RE THEIR EMPLOYER,
THE HEALTH INSURANCE
MARKETPLACE, THROUGH PLACES
OUTSIDE OF THE MARKETPLACE, IF
THEY EXIST, AND PEOPLE LIVING
WITH HIV WILL BE ABLE TO USE
MEDICARE AND OTHER PUBLIC HEALTH
INSURANCE AS WELL.
IT IS IMPORTANT TO RECOGNIZE AND
UNDERSTAND THAT PEOPLE LIVING
WITH HIV AND AIDS WHO ARE
ELIGIBLE TO ENFEDERAL OTHER
HEALTH COVERAGE, ETHER IT'S
MEDICAID OR A PRIVATE PLAN 234DS
OUR OUTSIDE THE MARKETPLACE,
RYAN WHITE FUND CAN CONTINUE TO
BE USED TO PAY FOR SERVICES NOT
COVERED AR PARTIALLY COVERED BY
THE PUBLIC PROGRAM OR BY THE
PRIVATE HEALTH INSURANCE PLAN.
SO PEOPLE LIVING WITH HIV NOT
ELIGIBLE FOR HEALTH COVERAGE AND
UNDER INSURED WILL CONTINUE TO
RELY ON THE RYAN WHITE PROGRAM
FOR FREE COMPREHENSIVE HIV MEDICAL
AND SUPPORT SERVICES.

SO ON THIS SLIDE WE HAVE A FEW
HELPFUL RESOURCES FOR YOU.
IT'S ALWAYS GREAT TO GO TO
HEALTHCARE.GOV.
THEY ARE CONSTANTLY UPDATING
INFORMATION HERE.
AND ALSO REMEMBER THAT STARTING
OCTOBER 1st OF 2013 -- SO OVER A
MONTH FROM NOW.
OPEN ENROLLMENT FOR THE
MARKETPLACES WILL BEGIN AND MORE
INFORMATION ABOUT THE PRIVATE
HEALTH PLAN OFFERING IN THE
MARKETPLACE INCLUDING BENEFITS
AND PRICING WILL ACTUALLY BECOME
AVAILABLE ON HEALTH CARE.GOV
OCTOBER 1st OF 2013.
IN ADDITION WE HAVE OUR HAB ACA
WEBSITE AND THEN THE TARGET
CENTER IS ALWAYS A GOOD RESOURCE
AS WELL.
SO WITH THAT, IT'S TIME TO OPEN
IT UP FOR QUESTIONS
>>> THE FIRST QUESTION FOR
TODAY'S WEBCAST IS, WILL THIS
PRESENTATION BE ARCHIVED?
THE ANSWER IS, YES, PRESENTATION
AND SLIDES WILL BE ARCHIVED ON
THE HAB WEBSITE.
THE SECOND QUESTION IS FOR OUR
CMCF COLLEAGUES.
WHEN DO YOU EXPECT INFORMATION
ABOUT STATE SELECTION FOR
BENCHMARK PLANS FOR THE
ALTERNATIVE BENEFITS PLANS TO
BECOME PUBLICLY AVAILABLE?
>> SURE.
THIS IS MELISSA.
THERE ISN'T A FORMAL MECHANISM
TO PUBLISH ONE DISCREET LIST OF
THE COMMERCIAL PLANS SELECTED BY
A STATE.
MORE LIKELY WHAT WILL HAPPEN IS
THAT AS WE APPROVE ALTERNATIVE
BENEFIT PLANTS, STATE PLAN
AMENDMENTS, THOSE WILL BE
PUBLISHED TO OUR WEBSITE AND IN
THAT TEMPLATE WE THA WE APPROVE
YOU'LL BE ABLE TO SEE THERE'S A
PLACE FOR THE STATE TO IDENTIFY
THE COMMERCIAL PLAN THAT THEY
HAVE ECT HAVED TO DEFINE EHB.
IT WILL BE BASED ON A LOOK AT
THE APPROVED ALTERNATIVE BENEFIT
PLANS THAT PEOPLE WILL BE ABLE
TO SEE THAT INFORMATION.
>> A RELATED QUESTION IS, WHEN

WILL THE PLANS PARTICIPATING IN
THE FEDERAL MARKETPLACE BE
ANNOUNCED?
WILL THOSE PLANS BE THE SAME FOR
ALL STATES PARTICIPATING IN THE
FEDERAL MARKETPLACE OR WILL THEY
VARY FROM STATE TO STATE?
>> THIS IS LISA.
AS FAR AS THE PLANS THAT WILL
PARTICIPATE IN THE EXCHANGES,
THEY WILL VARY FROM STATE TO
STATE.
AND OUR GOAL IS TO HAVE
INFORMATION ABOUT THOSE PLANS
AVAILABLE IN OCTOBER.
>> THANK YOU.
ANOTHER QUESTION FOR OUR CCIIO
COLLEAGUES IT IS MY
UNDERSTANDING PLANS ARE REQUIRED
TO REPORT DRUG LISTS TO THE
FEDERAL MARKETPLACE, STATE
MARKETPLACES OR OPM.
WILL THIS DRUG LIST BE AVAILABLE
TO THE PUBLIC AND WHAT IT
INCLUDE DISCLOSURE OF ANY
LIMITATIONS ON COVERAGE OF
CERTAIN DRUGS?
>> THE INFORMATION THAT WILL BE
MADE AVAILABLE REGARDING DRUG
COVERAGE WILL BE A LINK TO THE
PLAN'S FORMULARY.
YOU SHOULD BE TO GO THERE.
>> AND FOR MEDICAID AND
MARKETPLACE PLAN, WILL ALL HIV
MEDICATIONS BE AVAILABLE WITH A
DOCTOR'S PRESCRIPTION WITHOUT
PRIOR AUTHORIZATION?
>> AT LEAST FOR THE MARKETPLACE
PLAN, THE DRUGS THAT ARE
AVAILABLE, AND THE REQUIREMENTS
TO OBTAIN THOSE WILL VARY.
AGAIN, FROM PLAN TO PLAN AND
STATE TO STATE.
HOWEVER, IN THEORY, YOU SHOULD
BE ABLE TO GET ANY DRUG THAT YOU
NEED, BECAUSE ALL ESSENTIAL
HEALTH BENEFIT PLANS MUST HAVE
AN EXCEPTIONS PROCESS.
SO IF YOU NEED A DRUG NOT
COVERED BY THE PLAN AND IT'S NOT
ON THE FORMULARY LIST, SUBMIT
DOCUMENTATION SHOWING IT IS
MEDICALLY NECESSARY, YOU SHOULD
BE ABLE TO GAIN ACCESS TO THAT
PARTICULAR MEDICATION.
>> AND SIMILARLY ON THE ALTER
BENEFIT PLAN, MEDICAID SIDE,

AGAIN, MIRRORING THE
PRESCRIPTION DRUG BENEFIT UNDER
THE EHB REG REGULATIONS AND
STATISTICS MUST BE ENROLLED TO
GAIN ACCESS TO CRITICALLY DRUGS
THAT ARE NOT COVERED BY THE PLAN
AND CURRENTLY ALLOWED UNDER THE
TRADITIONAL MEDICAID AND WILL
ALSO BE PERMITTED UNDER THE
ALTERNATIVE BENEFIT PLANS.
>> THE QUESTION RELATED TO THAT
ONE, FOR THE COLLEAGUES, IS
THERE A REQUIRED TIME FRAME FOR
THE CONSIDERATION OF DRUGS THAT
ARE CLINICALLY NECESSARY AND ARE
MEETING THAT PRIOR AUTHORIZATION
PROCESS?
>> UNDER MEDICAID, THE 1927
RULES CONTINUE TO APPLY.
THAT IS 1927 OF THE ACT.
SO THEY WILL NEED BE ABLE TO
TAKE SOME TIME OF ACTION WITHIN
24 HOUR, AND ALSO MAKE AVAILABLE
A 72-HOUR EMERGENCY SUPPLY IF
NEEDED.
>> THANK YOU.
FOR OUR COLLEAGUES WHERE CAN
CLIENTS GET HELP LEARNING ABOUT INSURANCE
COVERAGE OPTIONS AND WHAT
BENEFITS OF PROVIDED UNDER PLANS
OAF OFFERED IN THE MARKETPLACE?
>> A GREAT QUESTION.
I REALLY WOULD LIKE TO REFER
CLIENTS TO HEALTH CARE.GOV.
AND REFER THEM TOP MEDICAID.GOV,
AND THERE'S GOING TO BE MORE
INFORMATION THERE ABOUT THE
ALTERNATIVE BENEFIT PLANS.
AS THEY COME THROUGH.
ANOTHER GREAT RESOURCE IS THE
HAB AFFORDABLE CARE WEBSITE.
INFORMATION WOULD BE RELEVANT TO
RYAN WHITE GRANTEES, AND THE
AFFORDABLE CARE ACT ON THE AP
WEBSITE ALONG WITH HRSA'S
GENERAL AFFORDABLE CARE WEBSITE
AS WELL AS THE TARGET CENTER AS
WELL.
>> THANK YOU.
FOR OUR COLLEAGUES AT CCIIO,
I WAS UNDER THE IMPRESSION ALL
PLANS IN THE MARKETPLACE WOULD
BE REQUIRED TO COVER PREVENTIVE
CARE AT NO ADDITIONAL COST TO
THE CONSUMER.
WHY ARE THERE OUT OF POCKET,
MAXIMUM OUT OF POCKET DEDUCTIBLE

IF THE SERVICES ARE FREE UNDER
THE MARKETPLACE PLANS?
>> THERE ARE REQUIREMENTS THAT
THE PLANS PROVIDE, PREVENTIVE
SERVICES AT ZERO COST SHAREINGS,
BUT THERE ARE OTHER BENEFITS
COVERED OUTSIDE OF THE
PREVENTIVE SERVICES THAT ARE NOT
SUBJECT TO THE ZERO COST SHARING
REQUIREMENT
REQUIREMENTS, AND THEREFORE THE
LIMITATION ON OUT OF POCKET
SPENDING WOULD APPLY TO YOUR
SPENDING ON THE THINGS THAT COST
MONEY.
THAT ARE NOT THE ZERO COST
SHARING BENEFITS.
>> WE HAVE A QUESTION FROM
DAVID.
FROM MARYLAND.
YOUR LINE IS OPEN.
>> YES.
RESIDENCY REQUIREMENTS.
IF SOMEONE IS ENROLLED IN A
STATE WITH A MEDICAID PLAN,
MOVES TO ONE WITH A HEALTH --
EXCHANGE PLAN, WHAT IS THE
COVERAGE LEVEL?
HOW ARE DIFFERENCES DECIDED
BETWEEN THE HIGHER LEVEL OF
COVERAGE, DIFFERENT MEDICATION
COVERAGE?
WHAT IS THE -- HOW ARE THOSE
PROCEDURES GOING TO TAKE, HAVE,
BE RESOLVED?
>> THIS IS MELISSA, AND I'LL
TAKE A STAB AT IT.
IT IS CONCEIVABLE, IN FACT VERY
LIKELY, SINCE THERE WILL NOT AT
LEAST IN THE IMMEDIATE FUTURE BE
A NATIONAL EXPANSION OF MEDICAID
THAT SOMEONE COULD BE IN A STATE
THAT HAS EXPANDED MEDICAID AND
THEN MOVE TO ONE THAT HAS NOT.
INCOME LEVEL WILL LARGELY CARRY
THE DAY IN TERMS OF WHAT --
WHAT -- ARE AVAILABLE TO THAT
PERSON IN THEIR ANY STATE.
IT THEY HAVE TOO MUCH INCOME TO
QUALIFY FOR MEDICAID IN THE
STATE IN WHICH THEY MOVE, THEY
WOULD NEED TO LOOK AT OTHER
OPTIONS FOR HEALTH INSURANCE.
THEY MIGHT MEET UNDER TO QUALIFY
IN THE FEDERAL EXCHANGE, BUT IF
THEY DON'T, THEN THEY NEED TO
FIGURE OUT WHAT, IF ANYTHING, IS

AVAILABLE TO THEM BASED AND
THEIR INCOME.
IT'S -- IF THEY MOVE TO A STATE
THAT HAS NOT EXPANDED MEDICAID,
IT'S NOT A SLAM DUNK THAT THERE
WILL ALWAYS BE SOME SORT OF
HEALTH INSURANCE PROGRAM FOR
THEM.
IT'S GOING TO REALLY DEPEND ON
THE INCOME STANDARDS AND USE IN
THAT STATE.
THE AFFORDABLE CARE ACT SOUGHT
TO STANDARDIZE THOSE IN TERMS OF
SAYING MEDICAID IS NOW AVAILABLE
TO EVERYONE AT OR BELOW 133%.
OF POVERTY LEVEL.
MOVED TO A STATE THAT DOES NOT
EXPAND MEDICAID, THEY NEED TO BE
AWARE OF THE INCOME, UPPER
INCOME LEVEL OF THAT STATE'S
MEDICAID PROGRAM.
THERE COULD BE THEN A GAP
BETWEEN WHAT MEDICAID COVERS
AND -- WHAT MEDICAID OFFERS AS
ELIGIBILITY IN THAT STATE VERSUS
INCOME THRESHOLDS FOR THE
EXCHANGE.
IF THAT PERSON FALLS INTO THE
GAP, THERE MIGHT NOT BE A
FEDERALLY AUTHORIZED HEALTH
INSURANCE PROGRAM FOR THEM.
IT'S VERY MUCH GOING TO DEPEND.
>> YEAH.
SO THIS IS LAURA.
AND SIMILARLY, RYAN WHITE AND
HOW RYAN WHITE IS COMPLEMENTING
THE SERVICES AVAILABLE THROUGH
MEDICAID OR THE EXCHANGES.
WHAT MIGHT BE AVAILABLE FOR A
CLIENT IN ONE STATE, THE
RESOURCES FOR RYAN WHITE IN THE
ALLOCATION PROCESS WILL BE
DIFFERENT IN ANOTHER STATE.
THEY'LL NEED TO INVESTIGATE THAT
AS WELL.
>> IT WILL BE DIFFICULT.
OKAY.
>> FOR OUR COLLEAGUES IN CMCF,
WOULD YOU CLARIFY WHETHER
INDIVIDUALS ARE MEDICALLY FRAIL
AND HAVE A CHOICE OF AN
ALTERNATIVE BENEFITS PLAN OR THE
STANDARD MEDICAID PLAN OR WILL
THE STATE MAKE THAT CHOICE FOR
THEM?
>> THAT'S A GREAT QUESTION.
THE INDIVIDUAL BENEFICIARY WILL

BE MAKING THAT CHOICE.
WE HAVE GIVEN STATES THE ABILITY
TO INITIALLY ENROLL INDIVIDUALS
IN THE NEW ADULT GROUP INTO ONE
OF THOSE TWO BENEFIT PACKAGES.
WE DID THAT BECAUSE WE
UNDERSTAND THAT THERE COULD BE A
TIME LAG IN THE IDENTIFICATION OF
INDIVIDUALS WHO ARE MEDICALLY
FRAIL AND THEN THE COUNSELING SO
THAT THEY CAN THEN CHOOSE A
BENEFIT PACKAGE.
WE DON'T WANT THAT TIME LAG TO
RESULT IN NO SERVICES BEING
PROVIDED.
SO WE HAVE GIVEN STATES THE
ABILITY TO KIND OF AUTO ENROLL,
IF YOU WILL, OR 234ISH8INITIALLY ENROLL
THEM INTO ONE OF THOSE BENEFIT
PACKAGES BUT THEY MUST HAVE THE
MECHANISM IN PLACE TO IDENTIFY
THEM AND GIVE THEM THE -- THE
INS AND OUTS OF WHAT EACH
BENEFIT PLAN COVERS.
THE ABT BASED AND ESSENTIAL
HEALTH BENEFITS VERSUS THAT IS
THE STATE APPROVED PLAN.
IF THE INDIVIDUAL FEELS THEY ARE
NOT ENROLLED IN THE RIGHT ONE
THEY NEED TO BE MOVED PROMPTLY.
IT'S THE INDIVIDUAL'S DECISION.
>>> A QUESTION FOR COLLEAGUES AT
CCIIO.
IS THERE A LIMIT ON THE AMOUNT,
A PLAN CAN INCREASE THE PREMIUM
DURING THE ANNUAL RENEWAL OF THE
PREMIUM?
>> CAN YOU PARTICIPATE FROM CCIIO
ON THIS COG, ACTUALLY THE HIL
BENEFITS TEAM.
THE QUESTION YOU ASKED IS MORE
FOR ANOTHER TEAM OF CCIIO.
WE WOULD HAVE TO DEFER TO THEM
ON THIS PARTICULAR QUESTION.
>> WE'LL TRY AND GET WITH THEM
AND GET AN TOONS OUR HRSA
COLLEAGUES SO PERHAPS THEY CAN
DISTRIBUTE AND BETTER
COMMUNICATE IT.
>> AND FROM HRSA.
I WANTED TO LET YOU KNOW WE'RE
GOING TO TRY TO GET TO AS MANY
QUESTIONS AS WE CAN.
OBVIOUSLY, SOME QUESTIONS OUR
SPEAKERS WILL BE UNABLE TO
ANSWER TODAY.
SO WE'RE HOPING THAT TO KEEP

TRACK OF THESE AND WE WILL BE
HOPEFULLY POSTING THEM ON OUR
HAB WEBSITE.
A SECTION, SO YOU WILL HOPEFULLY
GET ANSWERS TO EVERYTHING AT
SOME POINT IN TIME, JUST SO YOU
KNOW.
>> FOR OUR COLLEAGUES IN MCS,
CAN YOU FURTHER EXPLAIN THE
APPEALS PROCESS FOR GAINING
ACCESS TO A MEDICATION THAT IS
NOT COVERED BY AN ALTERNATIVE
BENEFIT PLAN?
WILL IT MIRROR THE SAME APPEALS
PROCESS AS THE QUALIFIED HEALTH
PLANS IN THE MARKETPLACE?
>> THE APPEALS PROCESS IS GOING
TO BE CONSISTENT AGAIN WITH WHAT
IS OUTLINED IN 1927, AND IN THE
WHOLE PRIOR AUTHORIZATION
PROCESS AND APPEALS.
IT'S NOT GOING TO MIRROR WHAT'S
IN THE QUALIFIED HEALTH PLAN.
THEY DO HAVE TO MEET THE
STANDARDS THAT WE HAVE
ESTABLISHED FOR TRADITIONAL
MEDICAID.
FOR APPEALS.
>> THANK YOU.
>> QUESTION FOR OUR COLLEAGUES
IN CCIIO.
WILL PLATINUM PLANS BE MORE
COMPREHENSIVE AND OFFER
GREATER COVERAGE THAN BRONZE OR
SILVER PLANS?
>> MORE CLARIFICATION ON THIS
ISSUE.
WITH THE CALCULATION OF AZ,
YOU'RE FOCUSED MORE ON THE COST
PERIMETERS OF THE PLAN AND NOT
SPECIFICALLY GOING INTO THE
DETAILS OF THE COVERAGE OF THE
INDIVIDUAL SERVICES.
SO WHEN YOU'RE TALKING ABOUT
ADDING AN ADDITIONAL DRUG, MORE
ABOUT THE COST OF THE TIER FOR
THE DRUG THAN IT IS ABOUT HOW
THE INDIVIDUAL DRUG ITSELF IS --
>> WE HAVE TWO MORE QUESTIONS.
THIS NEXT QUESTION IS, AGAIN,
FOR OUR COLLEAGUES AT CCIIO.
CAN PLANS IMPOSE GREATER COST
SHARING ON DRUGS THAT ARE
REQUESTED THROUGH THE EXPRESS
PROCEDURE?
EXCEPTIONS PROCEDURE?
>> THERE ARE NO REGULATIONS IN

THE ESSENTIAL HEALTH BENEFITS
THAT SPEAK TO THE COST OF DRUGS
THAT YOU ACQUIRE THROUGH THE
EXCEPTIONS PROCESS.
>> THANK YOU.
THE LAST QUESTION IS FOR OUR
CMTS COLLEAGUES.
IN STATES THAT ARE UNABLE TO
TRANSITION TO THE NEW
ALTERNATIVE BENEFITS PLAN BY
JANUARY 1, 2014, HOW WILL
COVERAGE OF ESSENTIAL HEALTH
BENEFITS BE HANDLED FOR
POPULATIONS THAT WOULD BE
ELIGIBLE FOR ESSENTIAL HEALTH
BENEFITS?
REMAIN UNCOVERED UNTIL THE
STATE GETS A BENEFITS PLAN IN
PLACE?
>> THE SHORT ANSWER IS, YES.
THE STATES ARE -- AGAIN, ONE OF
THE RAMIFICATIONS OF THE SUPREME
COURT DECISION IS THAT THERE'S
NO PASS/FAIL GRADE IF A STATE
DOES NOT HAVE EVERYTHING READY
TO GO BY JANUARY 1, SINCE THIS
IS AN OPTIONAL EXPANSION.
I THINK THE MAJORITY OF STATES
ARE INTERESTED IN HAVING A
JANUARY 1 GO LINE DATE IF FOR NO
OTHER REASON THAN MAXIMIZE THE
PERIOD OF TIME FOR WHICH THERE
IS 100% FEDERAL MATCH FOR THE
NEWLY ELIGIBLE INDIVIDUALS.
THOSE ARE, THOSE DATES ARE HARD
CODED IN STATUTE AND HAVE A DATE
CERTAIN TO START AND A DATE
CERTAIN TO STOP.
AND SO STATES WANT TO MAXIMIZE
THE PERIOD OF 100%, IF THEY HAVE
A DELAY IN IMPLEMENTING THEIR
PROGRAM AND DON'T HAVE THEIR
EXPANSION READY TO GO UNTIL,
SAY, JULY, 2014, THEN THEY'VE
LOST SIX MONTHS OF 100% FEDERAL
MATCH.
WITH THAT SAID, THERE ARE STILL
STATES THAT ARE MAKING DECISIONS
AS WE SPEAK ABOUT WHETHER OR NOT
THEY ARE GOING TO BE EXPANDING,
AND SO WE'LL HIT A TIME FRAME,
YOU KNOW, IN THE VERY NEAR
FUTURE WHERE IT'S JUST NOT GOING
TO MAKE PRACTICAL SENSE TO HAVE
EVERYTHING DONE BY JANUARY 1,
AND STATES MAY LOOK AT APRIL 1,
JULY 1, CASES LIKE THAT.

IN TOES CASES IT IS TROOP THE BENEFITS WILL NOT KICK IN UNTIL THE STATE'S EXPANSION.
IT COULD BE BENEFITS COME ONBOARD AT DIFFERENT TIME ACE CROSS THE COUNTRY AS STATES BRING THEIR EXPANSION PROGRAMS INTO IMPLEMENTATION AT DIFFERENT TIMES.
THAT'S A GOOD PARAMETER TO BE AWARE OF, THAT JANUARY 1 IS NOT A NATIONAL GO LIVE DATE EVEN FOR THE STATES THAT ARE EXPANDING.
>> GREAT.
SO I THINK THAT'S GOING TO CLOSE OUR Q&A SESSION FOR TODAY.
LIKE I SAID, WE WILL BE KEEPING TRACK OF ADDITIONAL QUESTIONS WE MAY NOT HAVE BEEN ABLE TO GET TO TODAY.
I REALLY, AND ON BEHALF OF HRSA I WANT TO THANK YOU EVERYONE, CCIIO, AND MTS, FOR BEING HERE TO ANSWER QUESTIONS FOR GRANTEES AND HOPEFULLY THIS IS INCREDIBLY USEFUL.
I ALSO WANT TO REMIND EVERYONE LISTENING IN IN IS A SURVEY ON THE MODULE, AND REQUEST THAT YOU TAKE A COUPLE OF MINUTES TO FILL THAT OUT SO THAT WE CAN GET SOME FEEDBACK ON THE USEFULNESS OF THIS WEBCAST AS WELL.
THANK YOU.